and biologicals with only an oral form furnished to ESRD patients is incorporated within the prospective payment system rates established by CMS in § 413.230 and separate payment will no longer be provided.

§ 413.176 Amount of payments.

(a) If the beneficiary has incurred the full deductible applicable under Part B of Medicare before the dialysis treatment, the intermediary pays the facility 80 percent of its prospective payment rate.

(b) If the beneficiary has not incurred the full deductible applicable under Part B of Medicare before the dialysis treatment, the intermediary subtracts the amount applicable to the deductible from the facility's prospective rate and pays the facility 80 percent of the remainder, if any.

EFFECTIVE DATE NOTE: At 75 FR 49199, Aug. 12, 2010, § 413.176 was revised, effective January 1, 2011. For the convenience of the user, the revise text is set forth as follows:

§ 413.176 Amount of payments.

For items and services, for which payment is made under section 1881(b)(7), section 1881(b)(12), and section 1881(b)(14) of the Act:

(a) If the beneficiary has incurred the full deductible applicable under Part B of Medicare before the dialysis treatment, Medicare pays the ESRD facility 80 percent of its prospective rate.

(b) If the beneficiary has not incurred the full deductible applicable under Part B of Medicare before the dialysis treatment, CMS subtracts the amount applicable to the deductible from the ESRD facility's prospective rate and pays the facility 80 percent of the remainder, if any.

§ 413.178 Bad debts.

(a) CMS will reimburse each facility its allowable Medicare bad debts, as defined in § 413.89(b), up to the facility's costs, as determined under Medicare principles, in a single lump sum payment at the end of the facility's cost reporting period.

(b) A facility must attempt to collect deductible and coinsurance amounts owed by beneficiaries before requesting reimbursement from CMS for uncollectible amounts. Section 413.89 specifies the collection efforts facilities must make.

(c) A facility must request payment for uncollectible deductible and coinsurance amounts owed by beneficiaries by submitting an itemized list that specifically enumerates all uncollectable amounts related to covered services under the composite rate.

(d) Bad debts arising from covered ESRD services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

[62 FR 43668, Aug. 15, 1997, as amended at 70 FR 47489, Aug. 12, 2005; 71 FR 69785, Dec. 1, 2006]

EFFECTIVE DATE NOTE: At 75 FR 49199, Aug. 12, 2010, § 413.178 was amended by revising paragraph (d), effective January 1, 2011. For the convenience of the user, the revised text is set forth as follows:

§ 413.178 Bad debts.

* * * * *

(d) *Exceptions.* (1) Bad debts arising from covered ESRD services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

(2) For services furnished on or after January 1, 2011, bad debts arising from covered ESRD items or services that, prior to January 1, 2011 were paid under a reasonable charge-based methodology or a fee schedule, including but not limited to drugs, laboratory tests, and supplies are not reimbursable under the program.

§ 413.180 Procedures for requesting exceptions to payment rates.

(a) *Outpatient maintenance dialysis payments.* All payments for outpatient maintenance dialysis furnished at or by facilities are made on the basis of prospective payment rates.

(b) *Criteria for requesting an exception.* If a pediatric ESRD facility projects on the basis of prior year costs and utilization trends that it has an allowable cost per treatment higher than its prospective rate set under § 413.174, and if these excess costs are attributable to one or more of the factors in § 413.182, the facility may request, in accordance with paragraph (e) of this section, that CMS approve an exception to that rate and set a higher prospective payment rate.

(c) *Application of deductible and coinsurance.* The higher payment rate is subject to the application of deductible and coinsurance in accordance with § 413.176.

(d) *Payment rate exception request.* Effective October 1, 2002, CMS may approve exceptions to a pediatric ESRD facility's updated prospective payment rate, if the pediatric ESRD facility did not have an approved exception rate as of October 1, 2002. A pediatric ESRD facility may request an exception to its payment rate at any time after it is in operation for at least 12 consecutive months.

(e) *Documentation for a payment rate exception request.* If the facility is requesting an exception to its payment rate, it must submit to CMS its most recently completed cost report as required under §413.198 and whatever statistics, data, and budgetary projections as determined by CMS to be needed to adjudicate each type of exception. CMS may audit any cost report or other information submitted. The materials submitted to CMS must—

(1) Separately identify elements of cost contributing to costs per treatment in excess of the facility's payment rate;

(2) Show that the facility's costs, including those costs that are not directly attributable to the exception criteria, are allowable and reasonable under the reasonable cost principles set forth in this part;

(3) Show that the elements of excessive cost are specifically attributable to one or more conditions specified in §413.182;

(4) Specify the amount of additional payment per treatment the facility believes is required for it to recover its justifiable excess costs; and

(5) Specify that the facility has compared its most recently completed cost report with cost reports from (at least 2) prior years. The facility must explain any material statistical data or cost changes, or both, and include an explanation with the documentation supporting the exception request.

(f) *Completion of requirements and criteria.* The facility must demonstrate to CMS's satisfaction that the requirements of this section and the criteria in §413.182 are fully met. The burden of proof is on the facility to show that one or more of the criteria are met and that the excessive costs are justifiable under the reasonable cost principles set forth in this part.

(g) *Approval of an exception request.* An exception request is deemed approved unless it is disapproved within 60 working days after it is filed with its intermediary.

(h) *Determination of an exception request.* In determining the facility's payment rate under the exception process, CMS excludes all costs that are not reasonable or allowable under the reasonable cost principles set forth in this part.

(i) *Period of approval: Payment exception request.* A prospective exception payment rate approved by CMS applies for the period from the date the complete exception request was filed with its intermediary until 30 days after the intermediary's receipt of the facility's letter notifying the intermediary of the facility's request to give up its exception rate and be subject to the basic case-mix adjusted composite payment rate methodology. ESRD facilities electing to retain their nonpediatric or pediatric exception rates (including self-dialysis training) do not need to notify their intermediaries. Once a facility notifies its fiscal intermediary in writing that it cannot retain its current exception rate, that decision cannot be subsequently reversed.

(j) *Denial of an exception request.* CMS denies exception requests submitted without the documentation specified in §413.182 and the applicable regulations cited there.

(k) *Criteria for refiling a denied exception request.* A pediatric ESRD facility that was denied an exception request may immediately file another exception request. Any subsequent exception request must address and document the issues cited in CMS' denial letter.

[62 FR 43668, Aug. 15, 1997, as amended at 70 FR 70331, Nov. 21, 2005]

EFFECTIVE DATE NOTE: At 75 FR 49199, Aug. 12, 2010, §413.180 was amended by adding paragraph (l), effective January 1, 2011. For the convenience of the user, the added text is set forth as follows:

§413.180 Procedures for requesting exceptions to payment rates.

* * * * *

(l) *Periods of exceptions.* (1) Prior to December 31, 2000, an ESRD facility may receive an exception to its composite payment rate for

isolated essential facilities, self dialysis training costs, atypical service intensity (patient mix) and pediatric facilities.

(2) Effective December 31, 2000, an ESRD facility not subject to paragraph (1)(3), is no longer granted any new exception to the composite payment rate as defined in § 413.180(1).

(3) Effective April 1, 2004 through September 27, 2004, and on an annual basis, an ESRD facility with at least 50 percent pediatric patient mix as specified in § 413.184 of this part, that did not have an exception rate in effect as of October 1, 2002, may apply for an exception to its composite payment rate.

(4) For ESRD facilities that are paid a blended rate for renal dialysis services provided during the transition described in § 413.239 of this part, any existing exceptions for isolated essential facilities, self dialysis training costs, atypical service intensity (patient mix) and pediatric facilities are used as the payment amount in place of the composite rate, and will be terminated for ESRD services furnished on or after January 1, 2014.

(5) For ESRD facilities that, in accordance with § 413.239(b) of this part, elect to be paid for renal dialysis services provided during the transition based on 100 percent of the payment amount determined under § 413.220, any existing exceptions for isolated essential facilities, self dialysis training costs, atypical service intensity (patient mix) and pediatric facilities are terminated for ESRD services furnished on or after January 1, 2011.

§ 413.182 Criteria for approval of exception requests.

(a) CMS may approve exceptions to a pediatric ESRD facility's prospective payment rate if the pediatric ESRD facility did not have an approved exception rate as of October 1, 2002.

(b) The pediatric ESRD facility must demonstrate, by convincing objective evidence, that its total per treatment costs are reasonable and allowable under the relevant cost reimbursement principles of part 413 and that its per treatment costs in excess of its payment rate are directly attributable to any of the following criteria:

(1) Pediatric patient mix, as specified in § 413.184.

(2) Self-dialysis training costs in pediatric facilities, as specified in § 413.186.

[70 FR 70331, Nov. 21, 2005]

§ 413.184 Payment exception: Pediatric patient mix.

(a) *Qualifications.* To qualify for an exception to its prospective payment rate based on its pediatric patient mix a facility must demonstrate that—

(1) At least 50 percent of its patients are individuals under 18 years of age;

(2) Its nursing personnel costs are allocated properly between each mode of care;

(3) The additional nursing hours per treatment are not the result of an excess number of employees;

(4) Its pediatric patients require a significantly higher staff-to-patient ratio than typical adult patients; and

(5) These services, procedures, or supplies and their per treatment costs are clearly prudent and reasonable when compared to those of pediatric facilities with a similar patient mix.

(b) *Documentation.* (1) A pediatric ESRD facility must submit a listing of all outpatient dialysis patients (including all home patients) treated during the most recently completed and filed cost report (in accordance with cost reporting requirements under § 413.198) showing—

(i) Age of patients and percentage of patients under the age of 18;

(ii) Individual patient diagnosis;

(iii) Home patients and ages;

(iv) In-facility patients, staff-assisted, or self-dialysis;

(v) Diabetic patients; and

(vi) Patients isolated because of contagious disease.

(2) The facility also must—

(i) Submit documentation on costs of nursing personnel (registered nurses, licensed practical nurses, technicians, and aides) incurred during the most recently completed fiscal year cost report showing—

(A) Amount each employee was paid;

(B) Number of personnel;

(C) Amount of time spent in the dialysis unit; and

(D) Staff-to-patient ratio based on total hours, with an analysis of productive and nonproductive hours.

(ii) Submit documentation on supply costs incurred during the most recently completed fiscal or calendar year cost report showing—

(A) By modality, a complete list of supplies used routinely in a dialysis treatment;

(B) The make and model number of each dialyzer and its component cost; and